

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-006293
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **719**

FILED FEB 18 1963

VS 300
Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF:

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF
MEDICAL CERTIFICATION
L. M. Tillman

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		c. CITY OR TOWN Kansas City	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3306 E. 20th		d. STREET ADDRESS (If outside, give location) 3306 E. 20th	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Edith Middle A. Last Atkinson		4. DATE OF DEATH Month 1 Day 31 Year 63	
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-18-05
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework	9. AGE (last birthday) 57
11. BIRTHPLACE (City and state or country) Shawnee, Kansas		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Walter Steward		13b. MOTHER'S MAIDEN NAME Minnie	
14. NAME OF HUSBAND OR WIFE William N. Atkinson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT William Atkinson 3901 Minnie	
18. CAUSE OF DEATH (Enter only one cause per) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Diabetes Mellitus		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> s.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	Month, Day, Year		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____. Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE L. M. Tillman M.D. Deputy Coroner		22b. ADDRESS 1618 Lydia Ave.	
22c. DATE SIGNED 2/1/63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-4-63	23c. NAME OF CEMETERY OR CREMATORY Highland Cemetery	
23d. LOCATION (City, town, or county) Kansas City, Mo			
24. FUNERAL DIRECTOR Jones & Stevens 2315 Linwood		25. DATE RECD. BY LOCAL REG. 2-4-63	
26. REGISTRAR'S SIGNATURE Ruth Long			

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.